

Office of the
Legislative Fiscal Analyst

FY 2005 Budget Recommendations

Joint Appropriations Subcommittee for
Health and Human Services

Utah Department of Health
Medical Assistance

Contents:

- 1.0 Summary
- 2.0 Issues
- 3.0 Programs
- 4.0 Additional Information

MEDICAL ASSISTANCE

Table of Contents

| | |
|---|----|
| 1.0 Summary | 5 |
| 2.0 Issues | 7 |
| 3.1 Medicaid Base Program | 12 |
| Federal Match Rate Change | 14 |
| Inflationary Increases | 14 |
| Caseload Growth and Utilization Increases | 14 |
| Summary of the Medicaid Program | 15 |
| Medicaid Services | 15 |
| Federal Poverty Level | 16 |
| Graph: Medicaid Eligibles, Recipients, and Expenditures | 18 |
| FY 2003 Medicaid Funding | 18 |
| Pressure on State Budgets | 18 |
| Aged | 20 |
| Blind and Disabled | 21 |
| Temporary Assistance to Needy Families and Foster Care | 22 |
| Temporary Assistance to Needy Families - Adults | 23 |
| Pregnancy | 24 |
| 3.2 Title XIX Funding for Human Services | 25 |
| 3.3 Medical Assistance - Clinics | 26 |
| 4.0 Additional Information | 27 |
| 4.1 Funding History | 27 |
| 4.2 Federal Funds | 28 |
| 4.3 Definitions of Medical Assistance Categories of Service | 29 |

1.0 Department of Health - Medical Assistance

Summary Medical Assistance is a joint federal/state entitlement service that provides health care to selected low-income populations.

There are three programs within the Medicaid line item as follows:

The Medicaid Base Program is the program most commonly identified with Medical Assistance. It provides a number of health services to specific eligible populations. While Federal law and regulations currently mandate some specific services within the program, the State has some flexibility and has been granted waivers that allow some latitude in program implementation. The FY 04 estimated base program makes up approximately 85 percent of all Medical Assistance expenditures. This program also includes the new Primary Care Network (PCN). The State funding for this was formerly in the Utah Medical Assistance Program (UMAP), but with the approval of the PCN waiver, went into the Base Program and is now matched with Federal funds.

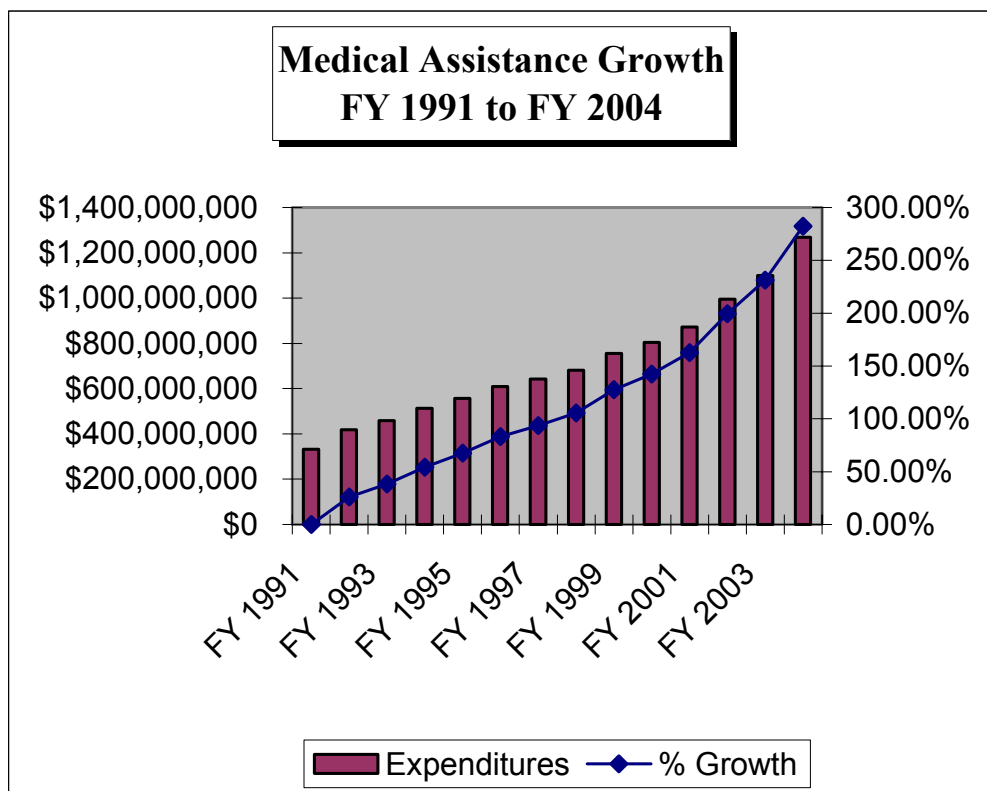
Title XIX Funding for the Department of Human Services consists of programs and services provided by the Department of Human Services to individuals who are qualified to receive Medicaid services. The State's share of the funding is from the General Fund appropriated to the Department of Human Services, which is transferred to the Medicaid program to be matched with Federal Funds.

The Utah Medical Assistance Program (UMAP) was the State program designed to provide a very limited number of services to a population that previously did not qualify for any other medical assistance programs. With the PCN now in place, this funding is now incorporated in the Medicaid Base program. However, there are still some costs for specialty physician services which are paid for entirely with State dollars and fees. These are included in the DOH Health Clinics Program.

The Analyst recommends a total budget for Medical Assistance for FY 2005 of \$1,296,050,000. The General Fund portion of the recommendation is \$229,967,400.

| | Analyst FY 2005 Base | Analyst FY 2005 Changes | Analyst FY 2005 Total |
|------------------------------|----------------------------|-------------------------------|-----------------------------|
| Financing | | | |
| General Fund | 229,967,400 | | 229,967,400 |
| Federal Funds | 894,413,300 | | 894,413,300 |
| Dedicated Credits Revenue | 71,311,400 | | 71,311,400 |
| Transfers | 99,881,500 | | 99,881,500 |
| Beginning Nonlapsing | 476,400 | | 476,400 |
| Total | <u>\$1,296,050,000</u> | <u>\$0</u> | <u>\$1,296,050,000</u> |
| Programs | | | |
| Medicaid Base Program | 1,101,996,300 | | 1,101,996,300 |
| Title XIX for Human Services | 190,014,100 | | 190,014,100 |
| DOH Health Clinics | 4,039,600 | | 4,039,600 |
| Total | <u>\$1,296,050,000</u> | <u>\$0</u> | <u>\$1,296,050,000</u> |
| FTE/Other | | | |
| Total FTE | 62.5 | 0.0 | 62.5 |

The Analyst's total recommendation for FY 2005 represents an increase of 2.1 percent when compared to the FY 2004 estimated level of expenditures. The increase is funded from federal funds, dedicated credits, and transfers; the FY 2005 General Fund level is the same as the FY 2004 appropriation. The following chart shows the growth in expenditures for Medical Assistance from FY 1991 through FY 2004.



2.0 Issues: Medical Assistance

2.01 Administrative Cost Intent Language

The 2003 Legislature approved the following intent language to be implemented by this division:

It is the intent of the Legislature that the budget analysis for the Department of Health be presented with a breakdown between costs of administration and services delivered and the number of citizens served and categorized by cost and type of service.

The Department reports that the Medicaid budget is 100 percent direct services. The following table shows the allocation of costs between administrative, indirect services, and direct services.

| MEDICAL ASSISTANCE | | | | |
|----------------------------------|----------------------------|-----------------------------|---------------------------|------------------------|
| ADMINISTRATIVE and SERVICE COSTS | | | | |
| FY 2003 Actual Expenditures | | | | |
| | Admin- <u>istration</u> | Indirect <u>Services</u> | Direct <u>Services</u> | <u>Total</u> |
| Medical Assistance Base | \$73,476 | | \$923,387,419 | \$923,460,895 |
| | 0.0% | 0.0% | 100.0% | |
| Title XIX Human Services | | | 172,348,339 | 172,348,339 |
| | 0.0% | 0.0% | 100.0% | |
| DOH Health Clinics | | | 4,353,430 | 4,353,430 |
| | 0.0% | 0.0% | 100.0% | |
| Total | \$73,476 | \$0 | \$1,100,089,188 | \$1,100,162,664 |
| | 0.0% | 0.0% | 100.0% | |

Source: Department of Health

2.02 Medicaid Program Intent Language

The Legislature approved six items of intent language in the FY 2004 Appropriations Acts for Medical Assistance:

It is the intent of the Legislature that the Department of Health will review with the Executive Appropriations Committee any Medicaid Program reductions or additions.

Also during the 2003 Legislative Session, HB 126, “Medicaid Benefit Amendments” passed which puts this requirement in statute. In fact, the language states that “. . . if the department implements a change in the Medicaid State Plan, initiates a new Medicaid waiver, submits an amendment to an existing Medicaid waiver, or initiates a new change requiring public notice under state or federal law, the department shall, prior to adopting the change, report to either the Legislative Executive Appropriations Committee or the Legislative Health and Human Services Appropriations Subcommittee . . .”

The Department reported two such changes, one in June 2003, dealing with disproportionate share hospital (DSH) payments (see fifth intent language report), and one in late December explaining a proposed rule change in the reimbursement methodology for federally qualified health centers (FQHCs). The Analyst presented the June change to the Executive Appropriations Committee in the June 17, 2003 meeting. A letter explaining the proposed rule change was sent to all of the members of the Executive Appropriations Committee. The Analyst believes that the department has complied with this intent language and the statutory requirements of notifying the Legislature of proposed changes. With the statutory language in place, the Analyst recommends that the intent language be discontinued.

It is the intent of the Legislature that the Department of Health continue to offer chiropractic coverage as part of the Medicaid benefit package.

The Medicaid program did continue its coverage of chiropractic services.

It is the intent of the Legislature to improve the oral health status, and thereby improve the overall health of low-income Utahns through increased utilization and access to dental services for Medicaid recipients, especially children. It is intended that this be accomplished as funding permits, by (1) increasing the participation of dentists in the Medicaid program by increasing the Medicaid reimbursement for dental services, (2) implementing a case management system to encourage more appropriate and timely access of Medicaid dental benefits by Medicaid recipients, and (3) implementing an early intervention/prevention and education program aimed at increasing the awareness of the importance of oral health among this population.

The purpose of this intent was to take measures to improve the oral health of Utahns. While efforts to do this have been taken, without additional funding, major improvements will be difficult.

It is the intent of the Legislature that the Department of Health and the Legislative Fiscal Analyst's Office project the effects of cuts made to the Department beginning in FY 2002. Particular notice shall be paid to the human toll of loss of services by individuals and families, and to the degree which cost-shifting to other, more expensive services occurs in the health and human services sector. The Department of Health shall report its findings to the Health and Human Services Appropriations Subcommittee.

The Department's report is included with its outcome report and can be found behind Tab 16.

It is the intent of the Legislature that the Utah Department of Health use any and all intergovernmental transfers from units of local government to draw down federal match in order to generate additional Medicaid funding for rural publicly-owned hospitals. The Legislature intends that both the amount of the intergovernmental transfer and the federal match monies it generates be returned to the rural publicly-owned hospital in the local governmental unit from which the intergovernmental transfer was received in order to maximize the funding available to such hospitals up to the payment limits for disproportionate share hospitals and the Medicare upper payment limits, which limits the Legislature intends the Department of Health to calculate as soon as possible. It is further the intent of the Legislature that if such intergovernmental transfers from units of local government, together with the federal match monies they generate, when used to pay rural publicly-owned hospitals cause the Medicaid program to exceed the disproportionate share limits or the Medicare upper payment limits, the other disproportionate share arrangements the Department currently has be adjusted up to \$1,000,000 in federal funds to permit the maximum possible payments to rural publicly-owned hospitals. The Legislature intends the Department of Health to amend the Medicaid State Plan wherever necessary in order to implement these intergovernmental transfers, the federal match, and the increased payments to rural publicly-owned hospitals.

The Department has submitted a State Plan change that allows the San Juan hospital to receive a \$1 million DSH payment. It was reported to the Executive Appropriations Committee that this would enhance the viability of this rural publicly-owned hospital and the people who utilize its services. No cost shifting is predicted, nor is there any anticipated impact on state appropriations.

It is the intent of the Legislature that the Department of Health continue to reimburse nursing care facilities based on the Resources Utilization Group System (RUGS) which went into effect in FY 2003. It is further the intent of the Legislature that the Department maintain a rule which phases out over a three year period ending December 31, 2005, the component of property payments which is based on varying individual nursing facility property costs. It is further the intent of the Legislature to extend the nursing care facility \$5.00 hold harmless stop-loss provision to June 30, 2004.

The Department has continued utilizing the RUGS program for Medicaid nursing facility reimbursements.

2.03 Medicaid - Critical Funding Issues

Each year, several items are traditionally funded by the Legislature, since the federal government mandates that they be funded. However, with the allocation approved by the Executive Appropriations Committee, they are not included in the Analyst's recommendation for FY 2005. These three items include:

- **Federal Match rate change** – During most of the 1990's, the federal match rate change experienced reductions, requiring an offsetting increase in the General Fund to maintain the program at the current levels. For FY 2003 and FY 2004, and the upcoming year, however, the Center for Medicare and Medicaid Services (CMS, formerly Health Care Financing) has recalculated the federal match rate and determined that the rate for Utah should increase. This means that for the third year in a row, the federal government will pay a slightly larger portion of the Medicaid costs. In the past, when the rate decreased, the State had to increase the General Fund just to keep the program at the same level. For FY 2005, with the rate increasing, the State can reduce its General Fund contribution, while still maintaining the program at its current level. The projected amount of General Fund savings is \$3,864,600. In the past, the General Fund increase has not been included in the Analyst's recommendation; for FY 2005 the decreased General Fund requirement is not either.
- **Inflationary Increases** – Federal regulations require funding to increase to cover increased costs in certain specific categories of service in order to assure access to health care. The Department's total projected amount is \$60,705,900, of which, \$15,812,100 would be from the General Fund. The Analyst has identified an increase of \$32.1 million (\$8 million General Fund) for inflationary increases. This is significantly less than the Department's request. The Analyst recommends that the Subcommittee discuss the funding for Medicaid inflation in its additional funding priorities.
- **Utilization/Caseload Increases** – The number of individuals eligible for Medicaid services has grown significantly over the past few years. To compound this, the number of services per eligible is also increasing. With an increasing number of recipients and requests for more services, additional funding is required to cover the additional services provided. The Department's projections indicate the need for an additional \$82,025,500, of which \$21,960,300 would be General Fund support. The Analyst has identified \$69,579,000 for caseload and utilization growth, with \$18,566,400 from the General Fund. The Analyst recommends that the Subcommittee also discuss this funding in its additional funding priorities.

The Department's net total for these increases is \$135 million; the total General Fund required is \$33.9 million. These items have traditionally been funded in the past, but are not included in the Analyst's funded recommendation, due to the level of funding approved by the Executive Appropriations Committee for the Subcommittee. The Analyst recommends that these items be considered for additional funding on the Subcommittee's prioritization list.

3.1 Medical Assistance - Medicaid Base Program

Recommendation

The Analyst recommends an appropriation of \$1,101,996,300 for the Medicaid Base Program for FY 2005. The recommendation requires \$228,979,200 from the General Fund, which, with the other sources of revenue, is matchable by Federal funds in the amount of \$758,363,200.

Since Medicaid is a joint State/federal program, the federal government provides the major portion of the funding to administer and implement the program. In general, states chose to participate in the Medicaid program because of the substantial financial assistance from the federal government to help cover the costs of health services for people who otherwise would not be able to pay. The federal share is based on the state's per-capita income and is recomputed annually. Since Utah has a relatively low per-capita income, the federal portion is higher than most other states. For FY 2005, the federal medical assistance percentage (FMAP) for programs qualifying under Title XIX is projected to be 72.04 percent, meaning that for each Medicaid dollar of expenditure, the State provides 27.96 cents, with the federal government picking up the remaining 72.04 cents. The State has utilized various funding streams (dedicated credits and restricted funds) to make up its share. During the 1990s, as the State experienced economic prosperity, its per-capita income increased, which translated into an overall decrease in the federal match rate. The federal share of Medicaid expenditures was 74.58 percent in FY 1994, and experienced small percentage drops annually until FY 2002. The trend reversed in FY 2003, when it increased by 0.57 percent; a further increase in FY 2004 of 0.67 percent and the FY 2005 rate is projected to increase by 0.44 percent.

Other Medicaid Funding Sources

The Medicaid Restricted Account has been a source of funding that has been utilized to fund part of the State's match for the Medicaid program for the past several years. This account was originally established to capture any excess funds from the Medicaid program and keep them in a separate, nonlapsing account, for "... programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter 40." (UCA 26-18-402) The Legislature has used funds from this account in the past for the funding of the Medicaid program. Appropriations from this account over the past several years have effectively left the Medicaid Restricted Account with no balance. However, late in FY 2003 additional federal funds were provided to the State, freeing up approximately \$5 million of appropriated General Funds. This excess General Fund then lapsed into the Medicaid Restricted Account, as required by statute (26-18-402 (2)(a)).

Legislation was approved several years ago, which imposed assessments on hospitals and nursing facilities, then utilized those funds as "State" funds in order to draw down matching federal funds at the nearly three-to-one match rate. The assessment on hospitals was repealed five years ago; the assessment on nursing facilities was repealed three years ago. In both cases, the General Fund replaced the assessments, so that the Medicaid program remained whole. Nearly all of the funding for the Medicaid Base program is used to pay claims for services provided by health care providers to recipients. With the Primary Care Network in place and consolidated with the Medicaid Base Program, there is a small amount of funding in personal services and current expenses. These expenditures reflect state employees who are providing services in the PCN arena.

| | 2003 | 2004 | 2005 | Est/Analyst |
|---------------------------|----------------------|------------------------|------------------------|---------------------|
| Financing | Actual | Estimated | Analyst | Difference |
| General Fund | 198,954,125 | 229,020,506 | 228,979,200 | (41,306) |
| Federal Funds | 641,836,497 | 749,571,794 | 758,363,200 | 8,791,406 |
| Dedicated Credits Revenue | 47,873,911 | 61,761,200 | 68,278,800 | 6,517,600 |
| GFR - Medicaid Restricted | 1,573,000 | | | |
| Transfers | 40,219,454 | 43,735,300 | 45,898,700 | 2,163,400 |
| Beginning Nonlapsing | (1,366,509) | 476,404 | 476,400 | (4) |
| Closing Nonlapsing | (476,404) | (476,404) | | 476,404 |
| Lapsing Balance | (5,226,655) | | | |
| Total | \$923,387,419 | \$1,084,088,800 | \$1,101,996,300 | \$17,907,500 |
| Expenditures | | | | |
| Personal Services | 169,619 | 240,100 | 238,600 | (1,500) |
| Out of State Travel | | | 182,400 | 182,400 |
| Current Expense | 182,386 | 182,300 | | (182,300) |
| DP Current Expense | 7,117 | 7,200 | 7,200 | |
| Other Charges/Pass Thru | 923,028,297 | 1,083,659,200 | 1,101,568,100 | 17,908,900 |
| Total | \$923,387,419 | \$1,084,088,800 | \$1,101,996,300 | \$17,907,500 |
| FTE/Other | | | | |
| Total FTE | 4.0 | 4.5 | 4.5 | 0.0 |

*Non-state funds as estimated by agency

Federal Match Rate Change

The federal government computes the Federal Match Rate annually. In the past, the match rate has decreased each year. When it has decreased, the Legislature has then increased the General Fund allocation in order to keep the Medicaid program at a constant level. For FY 2002, for example, the Legislature approved an additional \$6.6 million to cover a \$6.8 million reduction of federal funds. In recent years, the match rate has increased slightly, beginning in FY 2003. An additional increase is projected for FY 2005. This means that for the same program level, the federal government will contribute a slightly larger percentage. In the past, the Legislature has funded the loss with new General Fund. For FY 2005, there will be additional Federal Funds, resulting in a small excess of General Funds, so that amount could be reduced or applied to the other increases. For FY 2005, the Analyst projects the additional Federal funding at \$3,864,600. This is simply a switch in the funding ratio and does not affect the level of services or the number of recipients covered. In years past, when Medicaid needed additional funds for the match rate change, the funding switch was not included in the Analyst's recommendation. Now that the General Fund base is higher than it needs to be, it is also not included in the Analyst's recommendation, which gives the Subcommittee some latitude to offset other FY 2005 Medicaid increases.

Inflationary Increases

Federal law requires that a Medicaid program must assure access to services. When costs increase, the State must increase its funding (to be matched with federal funds). The Analyst's recommendation does not include inflationary increases for any Medicaid services. The Department's request reflects an average inflationary increase of 6.570 percent (over total Medicaid expenditures), estimated at \$58,298,200 (\$15,124,100 from the General Fund). The primary driver of this increase is Pharmacy Services, as has been the case over the past several years. The projected inflation factor for Pharmacy is 12 percent (\$22.1 million); the other categories average five percent. The pharmacy increase reflects the continuing escalation of prescription drugs prices.

Caseload Growth and Utilization Increases

The Analyst projects an increase in the utilization and caseload of Medicaid services. This indicates that there is both an increasing number of Medicaid recipients and the total Medicaid population is using Medicaid services more often. The Department's projected amount for FY 2005 is \$83,342,900, of which \$21,960,300 would come from the General Fund. This reflects an increase of approximately 11 percent. The Analyst has identified a reduced level of growth and utilization, which would cost \$69,579,000 (\$18,566,400 General Fund). Again, this projected increase is not part of the Analyst's recommendation. The main categories showing large percentage increases include Hospital Services, Pharmacy, and HMOs.

Over the past couple of years, the Medicaid program has seen substantial increases in the number of people eligible for services. The growth has exceeded the Analyst's and the Department's expectations. Because Medicaid is an entitlement program, if a person meets the eligibility criteria, they are eligible for the entire array of Medicaid services and the State must provide them. In FY 2002, the growth was so great, that the program closed the fiscal year in a deficit position. The projections for FY 2003 were again short and the program would have again ended in a deficit position, but the Federal government provided each state with a supplemental Medicaid enhancement which allowed the Medicaid program to close its FY 2003 books with a surplus, which lapsed into the Medicaid Restricted Account.

Summary of the Medicaid Program

Medical Assistance is a joint federal/state entitlement service consisting of three programs that provide health care to selected low-income populations: (1) a health insurance program for low-income parents (mostly mothers) and children (nationally, about 28 percent of all births are covered by Medicaid); (2) a long-term care program for the elderly (nearly 70 percent of all nursing home residents are Medicaid beneficiaries); and (3) a funding source for services to people with disabilities (Medicaid pays for approximately one-third of the nation's bill for this population). Nationwide, Medicaid covers over 40 million people, or about 13 percent of all Americans and nearly half of those living in poverty.

Overall, Medicaid is an "optional" program, one that a State can elect to offer. However, if a State offers the program, it must abide by strict Federal regulations. It also becomes an entitlement program for qualified individuals; that is, anyone who meets specific eligibility criteria is "entitled" to Medicaid services. The federal government establishes and monitors certain requirements concerning funding, and establishes standards for quality and scope of medical services. Requirements include services that must be provided and specific populations that must be served. States may expand their program to cover additional "optional" services and/or "optional" populations. In addition, states have some flexibility in determining certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits, and service delivery.

Medicaid Services

There are currently 45 services included in the Medicaid Program. Of these, inpatient hospital, outpatient hospital, intermediate care facilities for the mentally retarded, long-term care, physician, dental, pharmacy, and health maintenance organizations make up approximately 66 percent of program expenditures. The line dividing mandatory and optional services is occasionally blurred by the fact that some optional services are mandatory for specific populations or in specific settings. A brief description of each service is found in Section 4.3.

| | |
|------------------------------|--|
| Mandatory Services | <p>Mandatory services in the Medicaid Program are those that the federal government requires to be offered if a state has a medicaid program. These include: inpatient and outpatient hospital, physician, skilled and intermediate care nursing facilities, medical transportation, home health, nurse midwife, pregnancy-related services, lab and radiology, kidney dialysis, Early Periodic Screening Diagnosis and Treatment, and community and rural health centers. The State is also required to pay Medicare premiums and co-insurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the poverty level.</p> <p>The Early Periodic Screening Diagnosis and Treatment Program is a mandatory program which requires the State to screen all Medicaid children at scheduled intervals. The mandate includes providing all medically necessary services that can be covered under the program, such as organ transplants or any other service needed, regardless of cost.</p> |
| Optional Services | <p>Optional Services require approval from the federal Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration or HCFA). These services are eligible for the state's FMAP matching funds. These include pharmacy, dental, medical supplies, ambulatory surgery, chiropractic, podiatry, physical therapy, vision care, substance abuse treatment, speech and hearing services. The only optional long-term care service is Intermediate Care Facilities for the Mentally Retarded. As noted above, some of these services may be mandatory for certain populations or in certain settings. It should also be noted that while the service, as a whole may be optional, once the state elects to offer that service, it must make it available to all qualified eligibles.</p> <p>Utah is one of the 49 states which has a Medicaid Program. For budgeting purposes, the Medicaid line item consists of three programs: the Medicaid Base Program, Title XIX Seeding for the Department of Human Services, and Health Clinics. These programs rely heavily on federal funds under Title XIX of the Social Security Act.</p> |
| Federal Poverty Level | <p>Eligibility for many of the new Medicaid Programs, which Congress has added in recent years, is based on a person's income relative to the federal poverty level. The following table shows the annual federal poverty levels for 2002 by family size. The table also shows 133 percent of poverty because coverage for pregnant women is mandatory for persons with incomes up to 133 percent of poverty. Currently the State has the option of raising eligibility for programs for pregnant women and children to 185 percent of poverty.</p> |

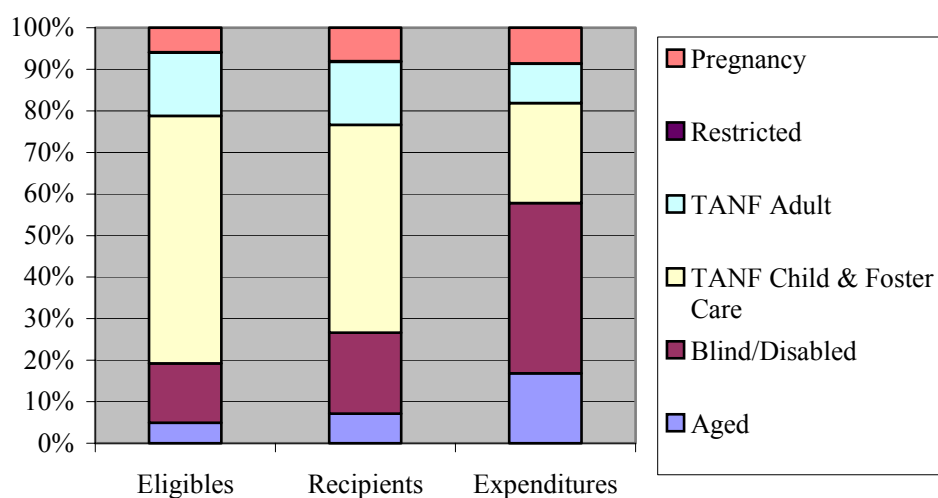
| 2003 FEDERAL POVERTY LEVELS | | | |
|------------------------------------|--------------------|--------------------|--------------------|
| <u>Family Size</u> | <u>100%</u> | <u>133%</u> | <u>185%</u> |
| 1 | \$749 | \$996 | \$1,386 |
| 2 | \$1,010 | \$1,343 | \$1,869 |
| 3 | \$1,272 | \$1,692 | \$2,353 |
| 4 | \$1,534 | \$2,040 | \$2,838 |
| 5 | \$1,795 | \$2,387 | \$3,321 |
| 6 | \$2,057 | \$2,736 | \$3,805 |
| 7 | \$2,319 | \$3,084 | \$4,290 |
| 8 | \$2,580 | \$3,431 | \$4,773 |
| 9 | \$2,842 | \$3,780 | \$5,258 |
| 10 | \$3,104 | \$4,128 | \$5,742 |

The state has designated five major population groupings that may receive health care from the Medicaid program. These include: (1) the elderly who receive federal SSI and persons in nursing facilities (grouped together as Aged); (2) Blind and/or Disabled individuals; (3) Children who receive Temporary Assistance for Needy Families (TANF) benefits, or are in the Foster Care program; (4) TANF Adults, with dependent children; and (5) Pregnant women. Each of these groups is discussed in more detail later in this section.

Much of the effort in the Medicaid program over the past several years was toward moving eligibles who live in the populated Wasatch front counties from the traditional "fee-for-service" providers to managed care, or health maintenance organizations (HMOs). The purpose behind this effort was to provide more cost-effective health care. This was the case early in the movement toward HMOs. However, in recent years the savings gap has shrunk. During the 2002 Legislative session, the two largest HMO providers, IHC and United, told the subcommittee that they would need an increase of eight percent in their rates in order to continue providing HMO services. The Legislature did approve an eight percent increase, but both of those providers later notified the State that they would be terminating their HMO Medicaid services. This prompted the move back to fee for service, although there is still the option with two HMOs still providing Medicaid services. This reversal had budgetary implications for FY 2003 that will carry to FY 2005.

The distribution of FY 2003 Medicaid eligibles, recipients, and expenditures for each group are shown in the following chart.

**Medicaid Eligibles, Recipients, and Expenditures
by Service Category**



FY 2003 Medicaid Funding

The 2003 Legislature increased funding for FY 2004 for the Medical Assistance budget to cover increases due to pharmacy inflation and general utilization/caseload growth. In addition, the Legislature approved funding to eliminate the spend down provisions for eligibility purposes and restored eligibility to aged, blind, and disabled individuals below 100 percent of the federal poverty. The Legislature also increase funding for the Ticket to Work program and restored physical therapy and audiology/hearing services.

Kaiser Report on States' Efforts to Control Medicaid Costs

The Kaiser Commission on Medicaid and the Uninsured, surveyed Medicaid officials in all 50 states. The following are excerpts from that report to demonstrate that Utah is not alone in its struggle to handle the Medicaid budget in extremely difficult economic times.¹

¹ "States Budgets Under Stress: How are States Planning to Reduce the Growth in Medicaid Costs?" The Kaiser Commission on Medicaid and the Uninsured, July 30, 2002

Medicaid was the driving force of the increase for the Department of Health, as the balance of the Department also experienced budget reductions. Across the country, states are facing similar situations with their Medicaid budgets exerting tremendous pressures on their budgets. This is attributable to increased enrollment due to post-welfare reform, eligibility expansions, and economic conditions. By the program's design, Medicaid costs can be expected to increase when the economy weakens and causes more people to enroll in the program. Because Medicaid is means-tested, more people qualify for Medicaid when incomes fall. This is generally also when state tax revenues fall. These factors create an inevitable tension for the state: the need for the program is frequently the greatest when the sources of state funds to devote to the program are the lowest. The survey identified 49 states that had plans to reduce Medicaid funding growth. Most states are using increased controls on pharmacy costs and payments to providers. States are also increasing cost-sharing, eliminating optional benefits, and reducing eligibility. These changes include:

Increasing controls on prescription drugs, including seeking larger discounts and rebates on purchases increasing usage of prior authorization, preferred drug lists, generic drugs, and limiting the number of prescriptions filled in a given month. *Utah has implemented requiring generic drugs, limiting the number of monthly prescriptions, and authorized the return of unused prescription drugs in nursing facilities.* Note: nine states require generic drugs and six limit the number of monthly prescriptions.

Cutting or freezing provider payments to doctors, hospitals, nursing facilities, and managed care providers. *Utah had not reduced reimbursement rates, but began reducing pharmacy product costs by paying average wholesale price (AWP) minus 15 percent instead of 12 percent (January 1, 2003) and reducing hospital outlier payments (January 3, 2003), and will implement additional reductions beginning July 1, 2003.* Note: There are 37 states that are either cutting or freezing hospital or other provider payments or are increasing their AWP discount, or other provider payments.

Eliminating benefits for Medicaid beneficiaries in 25 states, including dental benefits for adults, home health, podiatry, chiropractic services, eyeglasses, psychological counseling, and translator services. *Utah has eliminated adult dental, case management, and vision care.*

Initiating or increasing cost-sharing for Medicaid beneficiaries in 15 states. *Utah has increased copayments for hospital services, physician services, and prescriptions.*

Reducing the number of eligibles through lowering income thresholds, reducing transitional coverage, and changing the period of allowable medical expenses for the medically needy. *Utah has not resorted to this measure.* 27 states have reported that they will reduce or restrict Medicaid eligibility.

The following information details the categorical eligibility groups in the Medicaid program:

Aged

Individuals aged 65 and over qualify for Medicaid if they qualify for the Federal Supplemental Security Income Program, which provides an income of approximately 77.6 percent of poverty. They also qualify for food stamps. During FY 2003, an average of 10,959 people received services under the aged category of eligibility. Many of the elderly also qualify for Medicare coverage. The Medicaid Program pays for the premiums and deductibles for those eligible under both programs. Medicare pays the actual medical cost for most of these people. The largest expenditure for the elderly, outside of nursing facility services, is for pharmacy items, which are not covered under Medicare. Medicaid is also required to pay Medicare premiums, co-insurance, and deductibles for anyone qualifying for Medicare who has income up to 100 percent of poverty, but Medicare premiums only for those between 100 and 135 percent of poverty.

Medicaid also covers non-SSI aged people whose income does not exceed 100 percent of poverty. Aged people with income over 100 percent of poverty can spenddown to the Medically Needy Income Limit to receive Medicaid.

In July 1986, there were 5,794 nursing facility beds in the State. The census was 5,034 for an occupancy rate of 87 percent. Medicaid paid for 71 percent of all occupants. As of late 2003, there were 6,987 nursing facility beds which were certified, with a census of 5,091 as shown in the following table.

| N u r s i n g F a c i l i t y B e d s | | |
|--|--------------|--------|
| Private Pay | 1,069 | 21.00% |
| V A C o n t r a c t | 37 | 0.73% |
| P a r t V A C o n t r a c t | 0 | 0.00% |
| M e d i c a i d | 3,221 | 63.27% |
| M e d i c a r e | 764 | 15.01% |
| T o t a l | 5,091 | |
| | | |
| T o t a l C e r t i f i e d B e d s | 6,987 | |
| | | |
| P e r c e n t O c c u p a n c y | 72.86% | |

A Medicaid waiver has been obtained by the Division of Aging which will allow Medicaid to pay for some services in home and community-based settings. This is diverting some elderly people from nursing facility care.

Blind and Disabled

Persons receiving assistance due to blindness have always been part of the Medicaid Program.

Persons with disabilities are also eligible for services under the Medicaid Program. The monthly average number of blind and/or disabled individuals receiving Medicaid services during FY 2003 was 29,929. The criteria for disability require that a person be unable to participate in gainful activity for at least a year, or have a medical condition that will result in death. Among the disabilities covered are mental retardation, mental health, spinal injury, and AIDS. Income is limited to 73.5 percent of the federal poverty level for blind individuals and 100 percent for disabled individuals. An asset test similar to that for AFDC is required. Eligible individuals also qualify for food stamps.

The Blind and Disabled make up approximately 14 percent of the Medicaid eligible population, while accounting for approximately 19 percent of recipients. In FY 2003, this group accounted for 41 percent of total Medicaid expenditures. Institutional care for disabled individuals is included in this category.

**Intermediate Care
Facilities for the
Mentally Retarded
(ICF/MR)**

A special group of nursing facilities is Intermediate Care Facilities for people with Mental Retardation (ICF/MR). These facilities specialize in the care of people with disabilities. The individuals served by ICFs/MR are in need of more continuous supervision and structure, but are not significantly different from those served in other systems serving people with disabilities. ICFs/MR are long-term care programs certified to receive Medicaid reimbursement for habilitative and rehabilitative services and must provide for the active treatment needs which are met in a community environment. Nursing services are available for those requiring nursing and medical services.

There are specific federal regulations requiring active treatment programs and other treatment options. Current State law limits the size of new ICF/MR facilities to 16 beds or less. There are currently 13 privately-owned facilities with populations ranging from 12 to 82 and one State ICF/MR facility (the Utah State Developmental Center (USDC)) licensed for 290. Only three of the facilities meet the 16-or-fewer bed standard. ICFs/MR are an optional service in the Medicaid Program, but are part of the basis allowing the Home and Community Based waiver. Occupancy in the private ICFs/MR is near 100 percent and near 88 percent at the USDC. The average cost per client in an ICF/MR for FY 2003 was approximately \$48,900 which is a full-service program (including residential, day program, transportation, recreation, and medical services).

Temporary Assistance to Needy Families (TANF) and Foster Care

Aid to Families with Dependent Children (AFDC) was a joint federal-state program which provided financial assistance to families with children deprived of the support of at least one parent. On August 22, 1996, President Clinton signed the welfare reform bill, which ended the Aid to Families with Dependent Children (AFDC) entitlement program and replaced it with block grants to the states and the Temporary Assistance to Needy Families (TANF) program. In general, however, people who meet AFDC eligibility criteria that were in effect on July 16, 1996 will be eligible for Medicaid. Also, those people who qualify for a TANF grant are eligible for Medicaid.

There are two groups of people who qualify for Medicaid under the TANF program. These include: (1) those in the basic program where a child is deprived of the support of one parent, and (2) those in two-parent families that qualify under the unemployed parent program. The TANF-related programs account for approximately 60 percent of all eligible persons in Medicaid, 52 percent of Medicaid recipients, and 24 percent of total expenditures.

Over 90 percent of eligible families are deprived because of divorce, desertion, or unwed mothers. TANF families may also qualify for food stamps. Depending on family size, the AFDC grant and food stamps provide between 62 and 74 percent of the federal poverty level. There is an asset limit of \$2,000 for families in the TANF program. The asset limit does not include a residence or a car with an equity value of less than \$8,000. The average monthly number of TANF recipients during FY 2003 was 100,200. This is the category that has shown the most significant growth over the past couple of years.

Family Employment Program (FEP)

In addition to the basic Family Employment Program (FEP), there is also a program for unemployed two-parent families. This program provides cash assistance for seven months in any 13-month period. One parent in families in this program is required to work 32 hours a week (in an emergency work program) and spend at least 8 hours a week seeking regular employment. With the exception of the time limitation and work requirement, the criteria and benefits for the Family Employment Program - Two Parent (FEP-TP) are the same as those for the regular FEP. Federal law requires that the family be eligible for Medicaid for the full 12 months of the year. Besides those eligible through FEP cash assistance, there are several programs which provide transitional Medicaid coverage for periods of 4 months (for child support-related eligibles) or 24 months (for people who no longer receive cash assistance due to child support payments or earnings). Approximately 31 percent of the people who spend down to qualify for Medicaid come under the FEP category of eligibility. This portion of the FEP continues to grow. This likely is the result of self-sufficiency efforts in the FEP which have increased the number of people receiving transitional benefits.

Children in Foster Care are eligible for Medicaid coverage if they meet Medicaid program requirements. The State is responsible for their medical care. Most children placed in foster care have histories of abuse or neglect. This often means there are unresolved medical and mental health problems that must be dealt with.

In addition to the previously mentioned TANF children, there are four groups of children covered under the Medicaid Program. These are (1) medically needy children, (2) children under age 6 with family income up to 133 percent of poverty, (3) children and youth between age 6 and 18 with income up to 100 percent of poverty, (4) children in subsidized adoptions.

The Medically Needy Children program is for children who do not qualify for assistance under normal Family Medicaid because they are not deprived of the support of a parent. The asset test is the same as for TANF; the family is allowed to spend down to become eligible. This is an optional group, meaning it is not required by the federal government, and so coverage could be terminated. Many children who have been eligible for this group in the past have become eligible in the mandatory programs for children.

The program for children under age six with family income up to 133 percent of poverty is a mandatory program. The program for children born after September 30, 1983 with family income up to 100 percent of the poverty level is designed to provide coverage for children in poverty. There is an asset test required for children in this category of \$3,000 for a family of two; one home is exempted, and a car with an equity value of \$1,500 is allowed.

Each year, a number of children come into the custody of the State and are placed for adoption. Some of these children have serious medical problems which makes them hard to place. In some of these cases, the State subsidizes the adoption. Some families receive a small stipend to assist in the cost of care for these children, and the State covers the child's medical care under Medicaid until the child is 18 years old.

TANF Adults

The group referred to as TANF Adults includes those adults with dependent children who are either categorically or medically needy. Due to waivers initiated as a result of Utah's welfare reform initiative, any adult who qualifies for a financial payment through the FEP, qualifies for Medicaid as a TANF Adult. Some of the individuals may be required to "spenddown" to obtain their Medicaid card, which means that they must reduce their spendable income with payments to Medicaid or with medical bills which they have incurred. Some of the waivers expired at the end of 2000, others will continue.

Pregnancy

The prenatal/pregnancy program helps pregnant women receive prenatal care. The program covers the mother from the time of application to 60 days after the birth. A woman only needs to meet the eligibility requirements in any one month to be eligible for the balance of the pregnancy. Children born to women on this program can be covered on Medicaid (after the first 60 days) for the rest of the first year under the postnatal program.

Approximately one-third of all babies born in the State are paid for by Medicaid. This has been the case for the past several years.

Of the mothers in the program, approximately 23 percent are eligible under the FEP program, and 72 percent were eligible through the Pregnancy Program. Other mothers are eligible through other programs such as emergency medical care, blind or disabled, medically needy children, and foster children.

At the beginning of FY 2003, the Pregnancy Program had a caseload of approximately 13,696. During the year, the caseload averaged around 12,350.

**Administration/
Service Cost
Breakdown Intent
Language**

The 2003 Legislature approved this item of intent language for this program:

It is the intent of the Legislature that the budget analysis for the Department of Health be presented with a breakdown between costs of administration and services delivered and the number of citizens served and categorized by cost and type of service.

The Department reports that this budget is 100 percent direct services.

Almost all of the funding in the Medicaid program is used to cover the expenses of providing health care services to Medicaid recipients.

3.2 Medical Assistance - Title XIX Funding for Human Services

Recommendation

The Analyst recommends an appropriation of \$190,014,100 for the Title XIX funding for services provided by the Department of Human Services. There is no General Fund in this appropriation.

| | 2003 Actual | 2004 Estimated | 2005 Analyst | Est/Analyst Difference |
|---|----------------------|----------------------|----------------------|---------------------------|
| Financing | | | | |
| Federal Funds | 122,513,951 | 129,571,500 | 136,050,100 | 6,478,600 |
| Transfers | 49,834,388 | 51,394,300 | 53,964,000 | 2,569,700 |
| Total | <u>\$172,348,339</u> | <u>\$180,965,800</u> | <u>\$190,014,100</u> | <u>\$9,048,300</u> |
| Expenditures | | | | |
| Other Charges/Pass Thru | 172,348,339 | 180,965,800 | 190,014,100 | 9,048,300 |
| Total | <u>\$172,348,339</u> | <u>\$180,965,800</u> | <u>\$190,014,100</u> | <u>\$9,048,300</u> |
| FTE/Other | | | | |
| *Non-state funds as estimated by agency | | | | |

Summary

It has been the historical policy of the Legislature for the Department of Human Services to maximize federal funds. One of the ways this has been done is through accessing Medicaid for Human Services programs when possible.

Certain services and clients of the Department of Human Services qualify for funding under the Medicaid Program. Some of the programs that receive Medicaid funding are: the Utah State Hospital, the Utah State Developmental Center, Home and Community based waivers in the Divisions of Aging, Services for People with Disabilities, Youth Corrections, and Family Services.

The General Fund for these services is appropriated to the various divisions of the Department of Human Services who then "seed" or purchase federal funds through the Division of Health Care Financing. The agencies seeding Medicaid are able to purchase more or less than the amounts appropriated depending on available General Fund, qualifying programs and clients, and the priorities of the program. The Analyst has based his recommendation on the amount of funding requested by the divisions in the Department of Human Services.

Administration/ Service Cost Breakdown Intent Language

The 2003 Legislature approved this item of intent language for this program:

It is the intent of the Legislature that the budget analysis for the Department of Health be presented with a breakdown between costs of administration and services delivered and the number of citizens served and categorized by cost and type of service.

The Department reports that this budget is 100 percent indirect services.

3.3 Medical Assistance - Clinics

Recommendation

The Analyst recommends a funding level of \$4,039,600 for DOH Health Clinics. This program is similar to the previous Utah Medical Assistance Program, in that it is a state-funded only program. There are some dedicated credits and transfers, but the individuals receiving the services do not qualify for Medicaid, so the funding does not qualify for matching federal funds.

| | 2003 | 2004 | 2005 | Est/Analyst |
|---------------------------|--------------------|--------------------|--------------------|-------------------|
| Financing | Actual | Estimated | Analyst | Difference |
| General Fund | 629,375 | 946,894 | 988,200 | 41,306 |
| Federal Funds | 747,674 | | | |
| Dedicated Credits Revenue | 3,031,007 | 3,033,856 | 3,032,600 | (1,256) |
| Transfers | 18,850 | 18,850 | 18,800 | (50) |
| Total | \$4,426,906 | \$3,999,600 | \$4,039,600 | \$40,000 |
| Expenditures | | | | |
| Personal Services | 2,816,403 | 2,905,250 | 2,945,300 | 40,050 |
| In-State Travel | 40,259 | 40,300 | 40,300 | |
| Out of State Travel | 2,464 | 2,600 | 2,600 | |
| Current Expense | 534,282 | 543,150 | 543,100 | (50) |
| DP Current Expense | 8,276 | 8,300 | 8,300 | |
| Other Charges/Pass Thru | 1,025,222 | 500,000 | 500,000 | |
| Total | \$4,426,906 | \$3,999,600 | \$4,039,600 | \$40,000 |
| FTE/Other | | | | |
| Total FTE | 56.3 | 57.5 | 58.0 | 0.5 |

*Non-state funds as estimated by agency

Summary

The Clinics are designed to serve individuals who could not qualify for Medicaid or Medicare.

Administration/ Service Cost Breakdown Intent Language

The 2003 Legislature approved this item of intent language for this program:

It is the intent of the Legislature that the budget analysis for the Department of Health be presented with a breakdown between costs of administration and services delivered and the number of citizens served and categorized by cost and type of service.

The Department reports that this budget is 100 percent direct services. The direct services include the medical and dental services afforded to recipients.

4.0 Additional Information: Medical Assistance

4.1 Funding History

| | 2001 | 2002 | 2003 | 2004 | 2005 |
|---------------------------------|----------------------|----------------------|------------------------|------------------------|------------------------|
| Financing | Actual | Actual | Actual | Estimated* | Analyst |
| General Fund | 156,591,800 | 189,699,900 | 199,583,500 | 229,967,400 | 229,967,400 |
| General Fund, One-time | 26,000 | (6,398,500) | | | |
| Federal Funds | 589,884,966 | 664,418,167 | 765,098,122 | 879,143,294 | 894,413,300 |
| Dedicated Credits Revenue | 41,659,646 | 73,725,486 | 50,904,918 | 64,795,056 | 71,311,400 |
| GFR - Medicaid Restricted | 8,641,200 | 4,211,600 | 1,573,000 | | |
| GFR - Nursing Facility | 4,390,500 | | | | |
| Transfers | 72,115,345 | 67,975,893 | 90,072,692 | 95,148,450 | 99,881,500 |
| Beginning Nonlapsing | 339,347 | 1,607,505 | (1,366,509) | 476,404 | 476,400 |
| Closing Nonlapsing | (1,607,505) | (468,038) | (476,404) | (476,404) | |
| Lapsing Balance | | (1,234) | (5,226,655) | | |
| Total | \$872,041,299 | \$994,770,779 | \$1,100,162,664 | \$1,269,054,200 | \$1,296,050,000 |
| Programs | | | | | |
| Medicaid Base Program | 714,290,223 | 823,832,003 | 923,387,419 | 1,084,088,800 | 1,101,996,300 |
| Title XIX for Human Services | 150,726,583 | 162,127,128 | 172,348,339 | 180,965,800 | 190,014,100 |
| Utah Medical Assistance Program | 7,024,493 | 8,811,648 | | | |
| DOH Health Clinics | | | 4,426,906 | 3,999,600 | 4,039,600 |
| Total | \$872,041,299 | \$994,770,779 | \$1,100,162,664 | \$1,269,054,200 | \$1,296,050,000 |
| Expenditures | | | | | |
| Personal Services | 2,489,308 | 2,752,305 | 2,986,022 | 3,145,350 | 3,183,900 |
| In-State Travel | 7,763 | 25,090 | 40,259 | 40,300 | 40,300 |
| Out of State Travel | 422 | 2,403 | 2,464 | 2,600 | 185,000 |
| Current Expense | 434,054 | 543,297 | 716,668 | 725,450 | 543,100 |
| DP Current Expense | 5,895 | 3,843 | 15,393 | 15,500 | 15,500 |
| Other Charges/Pass Thru | 869,103,857 | 991,443,841 | 1,096,401,858 | 1,265,125,000 | 1,292,082,200 |
| Total | \$872,041,299 | \$994,770,779 | \$1,100,162,664 | \$1,269,054,200 | \$1,296,050,000 |
| FTE/Other | | | | | |
| Total FTE | 61.0 | 63.5 | 60.3 | 62.0 | 62.5 |

*Non-state funds as estimated by agency.

4.2 Federal Funds

| Program | | FY 2003 Actual | FY 2004 Estimated | FY 2005 Analyst |
|--|-----------------------------|---------------------------|------------------------------|----------------------------|
| Medicaid Base Program | Federal | \$641,836,497 | \$749,571,794 | \$758,363,153 |
| Title XIX Medicaid | Required State Match | 201,921,762 | 235,815,286 | 238,581,048 |
| | Total | 843,758,259 | 985,387,080 | 996,944,201 |
| Title XIX Funding for Human Services | Federal | 122,513,951 | 129,571,500 | 136,050,100 |
| Title XIX Medicaid | Required State Match | 38,542,889 | 40,763,194 | 42,801,361 |
| | Total | 161,056,840 | 170,334,694 | 178,851,461 |
| Utah Medical Assistance Health Clinics | Federal | 747,674 | | |
| Title XIX Medicaid | Required State Match | 0 | | |
| | Total | 747,674 | 0 | 0 |
| | Federal | 765,098,122 | 879,143,294 | 894,413,253 |
| | Required State Match | 240,464,651 | 276,578,480 | 281,382,409 |
| | Total | \$1,005,562,773 | \$1,155,721,774 | \$1,175,795,662 |

4.3 Definitions: Medical Assistance Categories of Service

| | |
|---|--|
| Aging Waiver | The aging waiver allows state Medicaid agencies to cover services not otherwise available under Medicaid to individuals 65 and over, who would be in an institution without these services. This allows these older adults to retain some level of independence and a greater quality of life by enabling them to remain in their own homes. |
| Ambulatory Surgical | Surgery on an ambulatory basis is provided. |
| Case Management Fees | Payments made to local health departments for case management services. |
| Child Health Evaluation and Care (CHEC/EPSTDT) | Screening, diagnostic, health care, treatment, and other measures to correct and/or ameliorate any defects and chronic conditions discovered in recipients under age 21. Utah's version of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program. |
| Chiropractic Services | Services which involve manipulation of the spine that a chiropractor is legally authorized to perform under state law. |
| Contracted Mental Health Services | Mental health services provided to children in foster care and under the authority of Division of Family Services/Division of Youth Corrections Services (DFS/DYC) are eligible for reimbursement effective 7/1/93. These services must be provided by a provider under contract with DFS/DYC. DFS and DYC will provide the state match for these services. |
| Dental Services | Diagnostic, preventative, or corrective procedures provided by a dentist in the practice of his/her profession. |
| Early Intervention | Diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers (up to age four) with disabilities. The program is administered by Family Health Services which contracts with providers consisting of multi-disciplinary teams of health care professionals who work with the family to evaluate and coordinate services to ensure that the needs of the child are met. |
| Group Pre/Postnatal Education | Classroom learning experience for the pregnant woman with the objective of improving knowledge of pregnancy, labor and childbirth, informed self care, and preventing development of conditions which might complicate pregnancy. Infant, feeding, or parenting classes may also be included. |
| Health Maintenance Organizations (HMOs) | Basic medical and dental covered services provided by health maintenance organizations. |

| | |
|---|--|
| Home and Community-Base Waiver for Developmentally Delayed/Mentally Retarded (DD/MR) | Provides services within the community to a limited number of individuals who meet criteria established for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services. The State may provide waived services, including residential treatment, day training, respite care, family support, and case management. |
| Home Health Services/Hospice | A program of intermittent and part-time nursing care provided in the patient's place of residence as an alternative to premature or inappropriate institutionalization. |
| Inpatient Hospital | A required service that provides medically necessary and appropriate diagnostic and therapeutic services for the care and treatment of injured, disabled, or sick people who must remain in the hospital for more than 24 hours. |
| Inpatient Hospital Mental-Mental Youth and Aged | Mentally ill, youth and aged clients in an inpatient hospital setting, requiring constant care. |
| Intermediate Care Facilities | Intermediate care facilities offer care to chronically ill patients. |
| Intermediate Care Facilities for the Mentally Retarded (ICF/MR) | Intermediate care facilities catering to mentally ill clients requiring less care than an inpatient hospital patient. |
| ICF/MR Day Treatment | Day treatment is provided to intermediate care and mentally retarded individuals. |
| Kidney Dialysis | A program for people who have irreversible and permanent end-stage renal disease and require a regular course of dialysis. |
| Lab and Radiology | Laboratory and radiological services are provided for the client. |
| Medical Supplies | Medical supplies necessary for treatment are provided to individuals who require them. |
| Medical Transportation | Transportation is provided to and from medical appointments and treatment when needed. |
| Mental Health Services | These include the continuum of mental health services provided by the 11 community mental health centers, including the three prepaid mental health clinics. The county mental health authorities provide the state match for these services. |

| | |
|--|--|
| Nutritional Assessment/Counseling | Service provided by a dietician for pregnant women with complex nutritional, medical, or social risk factors identified in early prenatal visits and referred for intensive nutritional education, counseling, and monitoring for compliance and improvement. |
| Occupational Therapy | Occupational therapy is provided to needy individuals to assist them in returning to the work force. |
| Optical Supplies | Services which include lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist to the extent permitted under state law. |
| Outpatient Hospital | A required service that provides medically necessary diagnostic and therapeutic services ordered by a physician or other practitioner of the healing arts. These services must be appropriate for the adequate diagnosis and treatment of the patient's illness. |
| Pediatric/Family Nurse Practitioner | Registered nurses with specialty training and certification, licensed within the State to provide general and preventive services within a specific specialty as authorized by licensure within the State. See specialized nursing above. (Coverage of these practitioners is mandated.) |
| Perinatal Care Coordination | Targeted case management for pregnant women. Services are provided to a woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirement for presumptive eligibility to receive ambulatory prenatal care services. The purpose is to coordinate care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational, and other services for the pregnant woman throughout pregnancy and up to the end on the month in which the 60 days following pregnancy ends. |
| Personal Care Services | The personal care services program enables recipients to maintain a maximal functional level in their place of residence through providing minimal assistance with the activities of daily living. |
| Pharmacy | Drugs prescribed by their respective physicians are provided to individuals which are required for treatment. |
| Physical Therapy | Services prescribed by a physician and provided by a physical therapist. |
| Physical Services | "Physician services", whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician, (1) within the scope of practice of medicine or osteopathy as defined by state law and (2) by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy. |
| Podiatry Services | Services provided by a podiatrist who is licensed under state law to render medical or remedial care for the foot and associated structures. |

| | |
|--|--|
| Pre/Postnatal Home Visits | Home visits are part of the management plan for a pregnant woman. The visits are for the purpose of assessing the home environment and implications for management of care, to provide emotional support, determine educational needs, provide direct care and encourage regular visits for prenatal care. |
| Pre/Postnatal Psychosocial Counseling | Evaluation to identify families with high psychological and social risks and follow up to develop a plan of care to provide or coordinate appropriate intervention, counseling, or referral necessary to meet the identified needs of families. |
| Private Duty Nursing | Nursing service provided in a client's home for up to 24 hours per day as an alternative to prolonged hospitalization or institutionalization of technology dependent individuals. This option, when compared to other alternatives, must provide quality and cost effectiveness over the long term, and requires participation of family members in the care during hours when nurses are not present. |
| Psychologist Services | Licensed psychologists may provide evaluation and testing to individuals with a diagnosis of delayed development (DD) or mental retardation (MR), early periodic screening diagnosis and treatment (EPSDT)-eligible Medicaid recipients and to victims of sexual abuse. They may provide individual, group, and family therapy to those eligibles. The Department of Human Services provides the state match for services provided to the Division of Family Services (DFS) and the Division of Services to People with Disabilities (DSPD) clientele. Psychological evaluation and testing for Medicaid clients who exhibit mental retardation, developmental disabilities or are victims of sexual abuse and are eligible for EPSDT. |
| Rural Health Services | Health services are provided to individuals who live in rural areas. |
| Skilled Nursing Facilities | Skilled Nursing Facilities offer skilled nursing care to chronically ill patients. |
| Skills Development | Medically necessary services to improve and enhance the health and functional abilities of the children ages 2 to 22 and prevent further deterioration. Services include individual or group therapeutic intervention to ameliorate motor impairment, sensory loss, communication deficits, or psycho-social impairments and skills training to the family to enable them to enhance the health and development of the child. Services are identified in the child's I.E.P. and provided by or under the supervision of specified licensed practitioners. |
| Specialized Nursing Service | The following specific practitioners are covered as Medicaid providers. Services of nurses practicing within a specialty area to the extent of licensure within the state. Four groups currently have provider status: <ol style="list-style-type: none"> 1.Certified Registered Nurse Anesthetists (CRNA) 2.Certified Registered Nurse Midwives (CNM) |

- 3.Certified Family Nurse Practitioners (CFNP)
- 4.Certified Pediatric Nurse Practitioners (CPNP)

| | |
|--|---|
| Specialized Wheel Chairs | Special wheel chairs are provided to needy individuals. |
| Speech and Hearing | Diagnostic, screening, preventive, or corrective services provided by a speech pathologist or audiologist for which a patient has been referred by a physician. |
| Substance Abuse | Treatment is given to clients for alcohol and drug abuse and misuse. |
| Targeted Case Management | Targeted case management services designed to assist an individual in a targeted group to gain access to needed medical, social, educational, and other services. In Utah, there are several targeted groups which assist individuals in the groups in planning, coordinating, and accessing needed services. |
| Targeted Case Management for AIDS | A set of planning, coordination, and monitoring activities that assist recipients in their target group to access services. |
| Vision Care Services | Diagnostic, screening, preventive, or corrective services provided by a physician skilled in disease of the eye or an optometrist to the extent permitted under state law. |